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PROMOTE PROTECT PROSPER

SC ADAP CENTRAL PHARMACY ANNUAL RECERTIFICATION

Return To:
Central Pharmacy
PO Box 809
State Park, SC 29147
(803) 896-6250 or (800) 856-9954

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE

Date Rec'd: _____ Status: _____

Status/Date: _____

PATIENT INFORMATION: To be completed by Applicant (Please print)

Name: _____
Last First Full Middle Name

Home Address: _____ City: _____ State: _____

Zip: _____ County: _____ Phone (H): (___) _____ (W): (____) _____

Mailing Address: _____ City: _____ Zip: _____

Birth Date: Mon ___ Day ___ Year ___ Sex: ____ Weight: _____ Social Security #: ____/____/____

Ethnicity (check one): ☐ Hispanic/Latino(a) ☐ Non-Hispanic /Latino(a) **Race (check all that apply):** ☐ White ☐ Black

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ Other_____

SOCIAL AND FINANCIAL DATA

Applicant and Other Members in Household	Relationship To Applicant	Sex	DOB	Place of Employment or Source of Other Income	Estimated **Yearly** Gross Income
Applicant					

Funds for this program come from Federal HRSA, Title II and State programs and are for low-income persons. This program is the payor of last resort. Persons with Medicaid cannot qualify for this program.

Current Physician _____ **Current Case Manager** _____

Are you allergic to or have reactions to any medicines?_____ If yes, which medicines? _____

Are you currently approved for Medicaid? ☐ Yes ☐ No **Application pending?** ☐ Yes ☐ No

Are you currently approved for Medicare? ☐ Yes ☐ No **Are you eligible for Medicare?** ☐ Yes ☐ No

Do you have insurance coverage for prescriptions? ☐ Yes ☐ No

CERTIFICATION/CONSENT: I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/ insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. **I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days.** ***By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, and/or case manager indicated on this page. By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me. Permission is also granted to DHEC to exchange medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.***

_____ _____
Applicant's Signature **Date** **Referring Physician or Case Manager** (Print legibly)

_____ _____
Referring Physician or Case Manager Signature **Date** **Organization** (Print legibly)

To be completed by Physician or Case Manager

The ***most recent*** CD4 (T4) lymphocyte count was _____ on _____ (date drawn). The ***most recent*** viral load result (if available) was _____ on _____ (date drawn).

Have you discussed with this patient the importance of adherence with the medications? ☐ ***Yes*** ☐ ***No*** _____

Central Pharmacy
P. O. Box 809
State Park, SC 29147
803-896-6250 – Columbia
800-856-9954 – Toll Free

Dear Sir or Madam:

This is a new enrollment form.

You must fill out and return this completed form within 90 days to remain enrolled in Central Pharmacy.

You must take this to your case manager or doctor for their help in completing this form. Their signature is required to complete this form.

Please fill in all the blanks and answer all the questions.

The **Social and Financial Data** is important and must be completed or the form will be returned to you for completion. Please tell us where you receive the money that you live on and also tell us if the amount that you put down is a weekly, monthly, or yearly amount. Please list all of your dependents in this section because this information may be useful in helping you to continue to qualify for this program. **You must include proof of your and your spouse's income with this recertification form**. This proof of income includes most recent; paycheck stubs, W2 forms, Federal Tax Return, Pensions, Unemployment Compensation statement, Social Security benefits, Alimony, Child Support, and Worker's Compensation. **If your income is zero, you will need to go to your local unemployment office and request a wage statement to verify zero income. Do Not Leave this Box Blank!!! You must provide the income paperwork with this recertification form to remain in the program.**

You are required to fill out this form in order to stay active on this program and to continue to receiving your medications. **Please fill it out and mail it back to us as soon as possible.**

If we do not have a current Recertification form, you will be closed from the program. We want you to stay healthy so **please call us if you have problems with this form or contact your case manager.**

Please complete and return this form as soon as possible to Central Pharmacy in the Business Reply envelope provided.
If you have any questions, please call us at **1-800-856-9954 or in Columbia at 896-6250.**
Sincerely,

ADAP Central Pharmacy Staff